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[A Word from the Chief, Medical Service Corps](#) Brig Gen Patricia C. Lewis

Good day. What a busy summer! I hope you had a chance to relax and spend time with family and friends. As we wrap up the summer and head into the holiday season, this is

a good time for all of us to reflect on why we joined the Air Force and why we wear the uniform. I've had the pleasure to meet meet face-to-face with many MSCs over the past few months and hear first-hand what's on people's minds. Overwhelmingly, the 365 day deployments have been the most talked about topic. These are difficult times for all of us! We have not experienced deployments like this since Vietnam. But unlike the Vietnam era, the Air Force is undergoing force shaping efforts to enable us to modernize our weapons systems while at the same time placing our personnel in warfighting positions. We all share the burden of increased ops tempo, continuing the mission at home and on the front lines. This is not the Air Force I joined 28 years ago, and probably not the Air Force you joined 5, 10, 15 years ago. Change is happening all around us and at a much quicker pace than in the past. We are facing new requirements outside our normal comfort zone, even outside our Air Force Mission and Doctrine; Army in-lieu-of (ILO) taskings, humanitarian support missions, Nation Building and Provincial Reconstruction Teams (PRTs), and even Army Combat Training. As we found out last month, our Colonels are being tasked for 365 day deployments, as well. We've been at war for many years now, but these are new challenges that we must overcome. We

have hard-charging, dynamic leaders in our Corps out front leading in the War on Terrorism. The feedback I hear from the field is these missions we are undertaking are very worthwhile and we are having a profound impact on the countries and people where we are serving. As one MSC said "this is the highlight of my career!"

As we enter into what may be our most difficult and challenging time in the history of our Corps, I am confident we have the right skill set, right attitudes, and we are the right Corps to tackle these issues, overcome adversity, and propel the Corps to new levels.



**Greetings from the Director, Medical Service Corps
&
Chief, Manpower and Organization:**

Col Denise Lew

Let me first comment on what a pleasure and honor it is to serve all of you as the Corps Director. I am humbled to be in this auspicious position, and hope I can make a difference to the quality of your career experience and effect positive improvements to Corps prominence during my tenure.

In my first few weeks, I've been in absolute awe of how much deliberate planning and tremendous effort collectively put forth by our senior leadership. I was totally impressed by how the design of our force development structure effectively influences our assignment process. With our total force so closely tied to validated requirements to support our readiness platform, and with the level of skill, knowledge, and experience necessary to fulfill the demanding requirements of the positions we fill, finding the right person for the right job is a daunting task. We do incredibly well given the constraints of our assignment process and the constant change and pressures we face in our evolving environment.

As many of you know, our toughest new challenge has been to absorb the impact of the ever-increasing In-Lieu-Of, or ILO deployments agreed upon by our CSAF to help support the Army. These are critical to the Air Force as we not only assist our Army counterparts who have borne the lion's share of the burden supporting OIF/OEF deployments, but this also helps the Air Force uphold its prominence in today's war efforts as our Service's overall role has been frankly overshadowed by our sister services. Unfortunately, this has normally involved 365-day deployments, which have been rare for Air Force medics since the Vietnam days and before we became an all-volunteer force. We are very grateful to those who have stepped up to the challenge, and we regret having to rely on the non-volunteer process to fill all the taskings. We are doing all we can to mitigate the effects of these taskings, and appreciate everyone's understanding and support.

Lastly, I have to admit the title of "Director of the Medical Service Corps" is somewhat disconcerting to me, as I see my role more as the "Director of the MSC Support Office." Our office is here to support you, not the other way around. I welcome your input on whatever subject you choose to bring up, and commit to you that our office will give everything careful consideration and advocate for changes that make sense for the good of the Corps and the AFMS.

MSC Association Reunion:

I had the pleasure of attending the 2007 Biennial Reunion of the MSC Association in San Antonio. Although first chartered 16 years ago as a retiree association, the organization now includes anyone who

has ever been an Air Force Medical Service Corps officer, including active duty, veterans, reserve, guard, and retirees.

Being my first reunion, I didn't know what to expect. On the surface, it appeared to be a retiree vacation package with several tours and social events planned throughout the three days of the event. Turns out a good portion of the reunion agenda was just that, geared toward providing an opportunity for long-time friends to tour area attractions and enjoy fun activities together. The formal meeting portions were primarily focused on Association business and retiree benefits, and of not much interest or applicability to active duty members.

What I didn't expect was the absolute thrill it was to meet and interact with many, many MSCs whom I've known or worked with in the past, and most I hadn't seen for 15-20 years. I also met many more individuals who were MSCs before I was on active duty, some of whom I'd heard about as "legends" of their time, and they all had fascinating stories to share about our MSC history and what they did back when they were on active duty. The attendees included several senior leaders, including seven former Corps Chiefs spanning back for three decades.

I also met the very first female MSC in the 58 year history of the Corps, Lt Libby Mayhugh (Class 53-C) and Capt Elaine Brauer (Class 62-C) both of whom had to separate from the Air Force when they got married and became pregnant. How times have changed! Having been a single mother for more than half my career, it made me appreciate how fortunate I was to have had the privilege of continuing my career and remain part of our Corps as the acceptance of women in the military has become more flexible.

The most important takeaway from the meeting was what a benefit it is to have former MSC leaders willing to take the time and put so much effort in creating this MSC Association-OUR Association-in order to offer us a chance to reflect on the rich MSC history of which we're all a part of, and to allow for interaction between generations of MSCs. The Association helps us preserve the legacy in keeping us all connected, with a chance to pass on stories first hand, talk about the great times we've shared during our careers, and enable us to shake the hands of those who paved the way for all of us.

Recommend to all MSCs on active duty to consider trying to attend the next Reunion, scheduled for October 2009. Alternatively, reach out and seek retired or former MSCs in your local area and invite them to meetings or socials with active duty MSCs. Finally, consider joining the Association and sustain the connection with your fellow colleagues, past and present. I assure you, it's worth it, and you will appreciate it more and more as the years go by, no matter how many years you spend as an MSC and where your career takes you. The Association website is: www.mscassociation.org.

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Chief's Corner

CMSgt Loretta Bryant

As always, life in the 4A0 world is exciting. CSS consolidation is probably the hottest discussion topic right now. Back in 1996, the 4A0 community decided to divest itself from CSS responsibilities. The AFMS converted about 260 4A0 positions to 3S0 positions. One of the issues our MTFs ran into as a result of the conversion was limited control over the number and quality of the 3S0 personnel assigned to the MTF. Often 3S0 positions in the MTF remained vacant for an extended amount of time. Eventually, 4A0s began backfilling the 3S0s vacancies.

In December 2005, PBD 720 mandated a 40% reduction of 3S0 personnel. In an effort to deal with such a drastic manpower cut, the 3S0 community convened a Lean Event. One of the outcomes of that Lean

Event was the decision to centralize all CSS functions at the Wing level. Although the DHP funded authorizations are not included in the consolidation, there is a good probability that some of the personnel filling DHP-funded positions will be pulled to staff the consolidated CSS at the Wing. I strongly suggest contacting your 3S0 functional manager on base to discuss the feasibility of retaining 3S0 personnel assigned to your staff.

While the CSS consolidation presents us with many challenges, it also provides us an opportunity to improve the efficiency and customer service in the CSS. If your MTF is already programmed to do some mil-to-civ conversions you may want to consider converting a military 3S0 position to civilian. This will provide continuity in your CSS staffing. Another option is to convert your 3S0 positions back to 4A0. In anticipation of this, CSS responsibilities have been added back into the 4A0 CFETP.

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Making a paycheck, or making a difference....

Col Mike Menning, Commander 379th EMDG, Al Udeid

When I woke up one morning in early August, about four weeks after I arrived at Al Udeid, I was thinking about the day, and my “routine”, if there is such a thing over here. I walked out of my room at 0630 into the 115 temperature and 85% humidity on the way to the medical group thinking how fortunate I was to be here. After all, it may be hot and humid, but the skies were perfectly clear. What I didn’t know was that later in the day, a 21 year-old Army Specialist was going to accidentally focus me into a renewed appreciation for the opportunities we have to make such a huge difference as a medical professional in a deployed environment.

I finished some paperwork, and was heading out the door about 1845 thinking about all the great things the folks accomplished that day, taking care of our patients brought here for our “In Theater Care Program”, or ITC. (ITC is a program where we bring servicemen from all over the theater who can be treated and returned to duty in 30 days or less.) I headed to my truck to go home, and half way there, I realized I’d forgotten some work I need to bring with me, so I turned around. I got out of the truck and walked back towards the office with the familiar crunch of gravel beneath my feet. Then out of the corner of my eye, I saw a shadow of someone sitting on the steps to one of our buildings. The sun was down, but what light remained let me recognize the person as one of our Army patients who was sent down here to have remove shrapnel removed from his shoulder. He was injured when an IED when off under his Humvee in Iraq. He would not have caught my attention, but his head was bent between his legs, and he appeared to be crying. Concerned, I walked over to him. The crunching gravel forced him to glance up and look towards me as I approached. When he saw it was an O-6 standing in front of him, he immediately shot up to attention, “good evening sir”, he said. The 21 year-old looked 17. He stood in front of me, and his eyes red from crying, tears still welled up in his eyes. His hand was to his forehead attempting a steady salute, but the shaking was obvious. I returned the salute, and asked him to sit back down. As I started to sit down next to him, I had no idea the impact, what I was about to hear would have on me. I asked him what was troubling him. He didn’t pretend for even a moment that nothing was wrong. “I think I need to talk with someone”, the Specialist said, his voice still shaking. My years as a commander prepared me for a lot, but this was really personal. “Are you comfortable talking to me here?”, I asked him. “Yes”, he answered, shaking his head up and down. Here’s what I heard, putting his story delivered to me in pieces, in more of a timeline for you, the reader.

Four weeks earlier, the Specialist got in the Humvee with three of his friends, to start the patrol mission assigned to them for the day. It was a good day for them, not a lot of hostile fire and the locals were very friendly that day. He really enjoyed what he was doing, and felt like he was making a difference helping

the people of Iraq get back on their feet. His experience wasn't anything like many of the negative media reports. He and his friends, who routinely patrolled together, were recognized and appreciated in their neighborhood. He'd been in Iraq for about 8-months by this point, and couldn't decide whether he was looking forward to go home or not...he really felt he was making that much of a difference, and had made the best friends he'd ever had. There were seven more months of a mission, and people he really enjoyed being around. He and his friends were making one final stop on a patrol before heading back to their FOB; they wanted to check in on an elderly couple his team had befriended. They said their goodbyes to the couple, and the four guys crawled up in the Humvee and headed home. Two minutes after pulling back on the road, an explosion tore through the Humvee, and the Specialist said he thought he remembered seeing himself flying through the air looking down on the Humvee as it was engulfed in flames. What he didn't know at the time, and found out only after he woke up in a medical unit, was that he was the only one who survived. His three closest friends had all been killed in the IED explosion. He told me the "need to focus" on the job allowed them to cubbyhole the "bad things" that happened on patrol, like seeing others get shot, being shot at, hearing about others "not making it". The Specialist continued to cubbyhole his experience, until he came to the 379th Expeditionary Medical Group. He was here to have some remaining shrapnel removed, that was beginning to limit his arm's range of motion. What he didn't count on, was finding out about the limits to his range of emotion. As he started talking with my nursing staff on the ward, he began to relax, and the stoic processes he'd built to cubbyhole "bad things" broke down. The night I met up with Specialist JD (not his real initials), he felt the impact of losing his three best friends, for the first time. As he cried recounting the day, he felt guilty that he'd actually survived. I put my arm around him, helped to lift him up, and asked him if he trusted me. He shook his head yes, as he couldn't speak. The tears were doing all the talking I needed to hear. I called up our Psychologist, and asked if he could see someone....of course, he did.

Two weeks later, Specialist JD understood what PTSD meant, and was on the road to healing, thanks to a great psychologist, and surgeon. He had tools with which to cope, and we put him in touch with someone close to his FOB, that he could continue talking to. JD wanted to go back to his unit. After all that, he still felt he was making a difference, and there was still work for him to do. Before he headed out, he stopped by my office, and had a big smile on his face, proudly letting me know he was going back to his unit....they needed him after all. I smiled back, shook his hand, and as I went to withdraw my hand, JD wouldn't let go. I held the tight grip we both had, and he said, "Thanks for being there for me sir". Ok, to be honest, I'm sure he saw the tears welling up in my eyes. "You're welcome, and thanks for being there for yourself", I said back, "and drop me an email when you get back to your unit." JD said, "yes sir", walked out, and arrived back at his unit the next day. I got an email from him telling me he was there.

"Thanks for being there". Probably the four most powerful words I've ever heard from a 21 year-old at my age. That's the point...."being there", or better yet, being here. Whether it's listening to a 21 year-old like JD, or our medical heroes who volunteer to deploy and help heal our warriors, us "old" folks need to be where these stories take place. JD will never know the impact he had on me, but I'm better for it. Being deployed afforded me that experience, and they are experiences I believe all or most of us who call ourselves senior leaders, should be able to relate to. There are thousands of these accounts being experience by our young medical folks, who're stepping up to the responsibility of deploying. I can't imagine not being able to relate to what many of them are going through, as they help other young men and women passing through our medical facilities, some in extraordinarily difficult locations. And, I can't imagine asking them to "go there" without having exhausted every opportunity to get there myself. It makes a huge difference to those who're recounting to us what they went through "over there" upon their return. Many of you know our "youngsters" are seeing enough, that it helps for them to talk about it when they get home. It helps for them to be able to look into the eyes of someone who has "a little gray hair", and know we've been there too.

I've thought back to JD a couple times since he's left, and can't help but admire a 21 year-old who even after all he's been through, wanted to get back to his mission in the AOR. Of all the things he told me, he never once complained about not sleeping in a comfortable bed, showering once every three days, or not being home for the holidays or his birthday. He may not have described it this way, but he is selfless, and didn't think about what he would miss, but what he could offer. JD stepped up. He is an example of someone who's making a difference in the AOR, just by being there for people. He's an example to all of us. Good luck JD, and thank YOU for serving over here and making a difference; you did with me!

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Honorable Service

Lt. Col. Maryanne Havard, 436th MDSS Commander

We all hope that our years of service will be remembered as honorable and that we contributed in some significant way to the mission. One of the most honorable missions is the one carried out at the Charles C. Carson Center for Mortuary Affairs here at Dover Air Force Base. That this unique Department of Defense mission is carried out in such a quiet and efficient manner is attributable to the many on active duty, in the Reserves and others who volunteer duty to make it possible. In my 30 years as a health professional in the civilian sector and the military, I can honestly say this is one of the hardest missions to carry out. The intricate details, scheduling, and cooperation that occur under very difficult conditions are absolutely amazing! This includes the young Honor Guard members who respectfully welcome our fallen Soldiers, Sailors, Marines and Airmen back home, to the people who work within the Port Mortuary, to the volunteer Aerial Port Squadron Airmen who work the outbound dignified transfers.

Inside the mortuary is the toughest job of all. Karen Giles leads the team at the mortuary and is one of the finest human beings I have ever met. Dedicated and caring, she ensures mission accomplishment seven days a week, 365 days per year, never forgetting about the people that make it happen. She truly exemplifies the many unsung heroes that ensure our fallen comrades are returned with dignity, honor and respect.

I first visited the mortuary to see my Medical Support Squadron radiology Airmen working there. As I walked through the operation, I quickly realized the care rendered at all stages of preparation. Airmen worked efficiently and patiently together. All Airmen I encountered took their responsibilities seriously, avoided any type of praise or fanfare, and indicated it was an honor for them to perform their duties. Given that their duties are usually very physical tasks which are not for the light-hearted, this is admirable. These folks are my heroes.

I also noticed everyone checking on each other and ensuring the job was completed at the end of the day before anyone left. I remember one particularly long day when I assisted with preparations. The mortician I was working with had traveled over from the D.C. area and spent several hours preparing one fallen soldier for return to his loved ones. As he was working on one of the soldier's limbs, others came over to assist and finish the preparations. As he finished, he fell into a chair, exhausted but knowing his skill and effort made a difference to that soldier's family.

The escorts that travel with each of our fallen heroes take this duty very seriously. Some are fresh from the battlefield themselves and many know the people they are escorting home. What a tough task. Last May when I served during outbound dignified transfers, I had the opportunity during that week to meet a new widow, a brother deployed to Iraq escorting his little brother home, an uncle and an officer who had sworn in the young Marine going home. Thankfully I was wearing my uniform on each of these occasions, without it I think I would have had great difficulty retaining my composure.

Why did I pick this topic? Because the mortuary is truly a part of the 436 AW mission and our Air Force mission. Possibly giving our lives is a risk we accept when we take the oath to serve our nation. It is reassuring to know if I or my children now serving were to be killed in action, the same care would be rendered. My heartfelt thanks go to all who provide this honorable service.

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Defense Institute for Medical Operations (DIMO) At It Again!

Major Sharief Fahmy, U.S. Central Command

When asked to “*Live The Dream*” we had no idea it would entail joining a team of professionals in the field of international emergency management with travels to Samoa to teach a Disaster Planner’s Course (DPC).

Why Apia, Samoa?

Every four years the nations of the Pacific come together in friendship to celebrate the South Pacific Games, a multi-national sporting event. The spirit of competition and sports has developed over forty years. The most recent South Pacific Games was held in Suva, Fiji and saw the introduction of a full program of 32 sports. The event included some 4,000 participants, representing 22 Pacific Island nations and territories.



DIMO Samoa Instructor Left to Right: Lt Col Morales (USAF), Major Fahmy (USAF), Mr. Bills (FEMA), Mr. Stokes (US Embassy, New Zealand), and Mr. Chevalier (FEMA) at Auckland Airport awaiting final transportation to Apia, Samoa

Courtesy photo

Specialist program (USAF/IHS) (Lt Col Luis Morales and Major Sharief Fahmy), Federal Emergency Management Agency (FEMA)(Mr. Joe Bills and Mr. Ray Chevalier) , and The United States Embassy in Wellington, New Zealand (Mr. Wayne Stokes) travelled to teach the course. The course was organized by the U.S. Embassy as part of its International Military Education Training (IMET) Program.

Live The Dream! Is the theme for 2007 XIIIth South Pacific Games to be hosted 25 August-8 September 2007 by the Island nation of Samoa. If successful, Samoa will set a new standard by hosting over 6,000 athletes and additional sporting events to include Archery, Athletics, Badminton, Baseball, Basketball, Beach Volleyball, Body Building, Boxing, Cricket, Football, Golf, Hockey, Judo, Lawn Bowls, Netball, Power Lifting , Rugby 7’s, Rugby League, Sailing, Shooting, Softball, Squash, Surfing, Swimming, Table Tennis, Taekwondo, Tennis, Touch Rugby, Triathlon, Outrigger Canoeing, Volleyball, Weightlifting, Wrestling to name a few. The Samoans are eagerly waiting to *Live the Dream!*

The Defense Institute for Medical Operations (DIMO) is an international training program associated with the U.S. Department of Defense. A five man team representing the United States Air Force International Health

The instructor team, led by Lt Col Luis Morales (Officer in Charge, International Health Specialist Program at Robins Air Force Base, Georgia), conducted the training program entitled "Disaster Planner's Course (DPC)." Training modules included: introduction to disaster planning; disaster response and regional trauma systems - emergency medical response; prevention - saving lives and saving resources; public health/preventive medicine in disasters; contingency/disaster operations; and environmental health management after natural disasters, communicable disease epidemics and disasters, and psychiatric response after disasters.

Forty-two Samoa participants, including government officials responsible for disaster planning and response, attended the training program at Samoa's Disaster Management Organization (DMO) complex in Apia, Samoa. This training program was funded by the United States Government through the IMET program. The Government of Samoa provided the training facility as well as other logistical support.

The week-long course introduced participants to disaster planning and response. Participants completed exercises on emergency situations to include natural and man made disasters. Although Samoa has experienced few large scale disasters, it realized the importance of being prepared as they gear up to host the South Pacific Games. Training was designed to address the range of emergencies from a destructive tsunami to a one-car motor vehicle accident. More importantly, the training venue brought together an interagency group of participants who will be required to work together in a disaster response situation.

After the March 2007 course revision, the DPC material had to be re-written to fulfill Samoa course's requirement. Whereas DPC was meant for countries without a disaster plan, Samoa had recently (November 2006) had approved their National Disaster Management Plan (NDMP) with subsequent legislation in 2007. Subject matter experts worked virtually with the revised DPC material incorporating the Samoa National Disaster Plan, the Samoa Disaster Act, Cyclone Plan and Tsunami Plan. Material was researched from open internet sources and from Ms. Filomena Nelson (Samoa Disaster Management Organization (DMO)), and Mr. Wayne Stokes. The DPC exercises based on the fictitious country of Muskania were completely rewritten for Samoa by Mr. Chevalier. The CAPSTONE event of the course was an exercise scenario featuring a tsunami which hit during the South Pacific Games 2007. Many of the discussions generated during the presentations involved items internal to Samoa. The DMO cadre sought to address their concerns while emphasizing the need to raise the level of cooperation among the various organizations. Some of the issues discussed include: 1) Terminology and the use of Emergency vs. Disaster, 2) Chains of authority and general knowledge of the NDMP, 3) Who has the ultimate authority to cancel the upcoming Pacific Games in case of an emergency/disaster? 4) Are the local emergency response vehicles capable of using "foam trucks" during a catastrophic power-grid fire? A resource solely dedicated to the Samoa airport.



Graduating Class of the Disaster Planner's Course Apia Samoa

Courtesy photo

The critiques from the students reflected and confirmed a statement written by Ms Nelson, which states the follows:

“... the course met our objectives from our perspective as the DMO and also from the DAC member agencies.... the course uses local and more realistic scenarios (i.e. not fictitious) and provided the participants with guiding principles, using Samoa National Disaster Management Plan and Act, using examples in the US... which extremely helped the participants understand the scenarios and how to prepare (planning) to respond.....so I would personally commend the efforts of the instructors and of course yourself Sir.....”

-- Ms. Filomena Nelson, DMO

The fa'a Samoa (Samoan way) exerts a strong influence on the everyday life of Samoans. Traditional culture impacts all facets of Samoan society, whether religious, economic or political. So not only did we get to *Live The Dream!* for a short while, we hope the synergy from the DPC course will add to the fa'a Samoa as they take the lead in hosting what history will show is a memorable South Pacific Games!

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Memoirs of a Programming Fellowship

Maj Tommy Franklin, Chief, Line Funded Medical Programming
Office of the Surgeon General

Please allow me to begin by giving you my “bottom line up front.” If you think you want to apply for a fellowship...or an EWI or an AFIT opportunity...go for it! You won't regret it. This past year has been one of the most professionally rewarding, and definitely the fastest, in my 17-year career thus far. I had the privilege of being the second MSC to experience a Programming Fellowship in AF/A8, formerly known as XP. The AF/A8 is the Deputy Chief of Staff for Strategic Plans and Programs, and I was assigned to the Directorate of Programs. While there have only been two Programming Fellows, with a third who started in August, there is quite a legacy of “who's who” in A8. On the line side, Gen Fogleman, former CSAF, used to be the Director of Programs, and there have been several others who have gone on to reach their fourth star to include, more recently, Gen Chilton, the new commander of US Strategic Command. In the Medical Service Corps, we have a few well-known individuals who have served an assignment in the Directorate of Programs as well, to include Col John Sell, now the Command Administrator of Air Force Space Command, and someone who used to be known as Lt Col Patricia Lewis. My point in sharing these names with you is to show that the Programming world can open up a lot of doors and possibilities for anyone brave enough to walk through them.

Now before you start thinking this is a paid political advertisement, I would like to share some practical lessons learned and some personal highlights from my experience. The absolute first thing I was instructed to do, before I even landed in Washington, DC, was to purchase a copy of *Assignment Pentagon* by Maj Gen Perry Smith, USAF (Ret). It was a quick read, but it gave me an excellent picture of what I was about to get into. It covered everything from the politics, work hours, and commute of the Pentagon to how to be a successful Action Officer. Once I arrived, I immediately found out that what I was getting into was actually a whole lot more than what I thought I had signed up for.

Prior to the Fellowship, I had the misunderstanding of thinking Programming was all about manpower forecasting. As an RMO at the MTF-level, I would submit a Financial Plan for the next fiscal year, but I didn't really worry about future years. I assumed someone in AF/SGMC (now SGY) was worrying about that. However, when I put my manpower hat on, we always looked down the road. In addition, manpower and staffing issues always seemed to be more dynamic than whether or not we had enough money to start a new initiative two or three years down the road. When we discussed money, the concern was always about the current fiscal year. Well, I quickly found out that Manpower is a piece of Programming, but at the end of the day, it's all about the money...whether you're buying planes, beans,

blankets, bullets, or people. By the way, AF/A1, formerly known as AF/DP, handles the Manpower piece of Programming, and they bring it to the Air Force Corporate Structure (AFCS). The AFCS is a dynamic process with many moving parts.

The heavy lifting in the Planning, Programming, Budgeting and Execution System is accomplished by the Air Force Board and the Air Force Group. The Board and Group have members from all of the functional areas across the Air Staff; Brig Gen Lewis and Col Beatty represent the SG, respectively. They make the hard choices on what Air Force Programs we can afford in two to six years and what Programs have to be reduced to the point of risk or even sacrificed. However, if the Program is so politically charged that they can't make the decision, then the Board Chair and the AF/A8 will take it to the Chief for a decision. As the humble MSC Fellow, I had the opportunity to participate in many levels of this process, from building briefing books and slides to prepping the AF/A8 for meetings with the Chief, the Combatant Commanders, and the Deputy Secretary of Defense.

I would now like to describe life in the Pentagon. Truthfully, it's not as dramatic as depicted on television. While there are operators planning and tracking the events around the world, most everyone in "the Building" is participating in Budget or Programming warfare. They are either fighting someone in the OSD camp, someone on Capitol Hill, another service, or someone in their own service. In spite of the political environment, though, it really is a neat place to work. You can feel the history as you walk the halls of the 65 year old building, and many of the halls have artifacts and pictures to tell the stories. It doesn't take you long either to figure out that the Air Force is just one part of a bigger whole as you see the thousands of Soldiers, Sailors and Marines filing into the entry control point with you each morning. One of my favorite parts of working at the Pentagon though was the last part of my bus ride each morning. As the bus would roll over the highest point on I-395N before hitting the Pentagon parking lot, a breath-taking view of the Washington skyline would appear with a glorious sunrise in the background. Each day I was reminded of what an awesome city this is, the Capitol of our great nation.

Finally, here are some personal highlights from my Fellowship experience. I had the opportunity to help prepare the Chief Programmer for the first-ever Combatant Command road show. No other Chief Programmer has ever taken the time to go brief their service's Program to each of the Combatant Commanders. As the warfighters, they need to know what capabilities each service can provide them, and by telling them where they fit into our Air Force Program, a lot of goodwill was achieved for future debates and Program Budget Reviews. Another highlight for me was working in the AFCS "Engine Room" during Program Review last fall. I was tasked with the responsibility of analyzing the Program Decision Memorandums coming out of OSD as they scrutinized the Program we had given them. Then I would take my findings and build the briefs for the AFCS. Then the Chief Programmer, the CSAF and the SECAF would formulate their response to OSD. Shortly after Program Review, I had the opportunity to help facilitate the first-ever Four Star Programming Summit. All of the four star generals in the Air Force came to the Pentagon to be briefed on the Program Budget going to the President. And finally, I had a chance to be a part of history by participating in the Air Force's 60th Anniversary Kickoff and Air Force Memorial Dedication.

My experiences this past year were not exactly the same as my predecessor's, nor will my successor's be the same as mine. However, each opportunity is what you make of it, and I believe this opportunity has not only made me a better MSC, but it has also enabled me to be a better Airman. This exposure to the "big Air Force" has shown me that we are all a part of something bigger than ourselves, but we all have a role to play and a contribution to make. I hope this sparks an interest in the junior MSCs who are on the fence about applying for an educational opportunity or the more senior MSCs who have been leery of the Programming world. As I stated in the beginning, go for it!

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MSCs and Community Disaster Preparedness

Capt Greg Baldwin, Operations Officer, Ramstein AB, Germany

Networking is something that we as MSCs do well. We network for our next job, we network with our fellow MSCs, and we network with our buddies across the base. In the medical readiness community, MSCs would be well served to put these networking skills to use in order to meet our disaster preparedness counterparts outside the gate. Fire, pre-hospital coordinator, county disaster personnel, etc. are all excellent sources of knowledge and expertise. We have much to learn from these professionals.

At my previous assignment, I was the National Disaster Medical System (NDMS) lead for the Phoenix region, and I can attest that these professionals have tremendous experience in managing real world crises. During a NDMS drill a few years ago, I was amazed by the performance of the members of the Phoenix and Scottsdale Fire departments. When presented with a challenge such as a lack of ambulances, they were right there with the answers and ready to help. Why? They had dealt with this sort of thing so many times before.

These professionals can learn from us as well. As a member of the military, you have automatic "street cred" and everyone looks to you to have the answers. Research has uncovered, however, that many of these civilian emergency planners have serious concerns about working with the military. According to a study that appeared in the Journal of Homeland Security and Emergency Management, many of these civilian planners are unaware of how to request military assistance during a disaster and are concerned about communicating with their military counterparts (<http://www.bepress.com/jhsem/vol3/iss1/2/>). This should be a wakeup call for all of us, and here are some ideas how we can address this perception:

- Start by connecting with your base counterparts: The "Three Amigos" during an on-base disaster are medical, security forces, and fire. Get to know these experts, and the other members of your base's threat working group really well. They will likely know who the key players are in the community.
- Seek out local community emergency preparedness committees, county disaster meetings, area hospital disaster meetings. Become a regular at these meetings and network like crazy.
- Learn to speak their language: Take some free FEMA courses (good for CEUs and college credit) regarding the Incident Management System at: <http://training.fema.gov/IS/crslist.asp>. Start with introductory course IS 100 and go on to some of the advanced courses as necessary. Become the expert.
- Show off what you do well and consider inviting your off base counterparts on base for a demonstration. From my experience, visitors are usually impressed with our field medical training and the In Place Patient Decon Team.
- Invite your off base counterparts to observe/participate in your disaster drills. For civilian hospital personnel, JCAHO mandates they participate in community disaster drills every so often to maintain their accreditation. You may be surprised at how many of your civilian counterparts are eager to play in your next pandemic influenza response drill.
- Determine who your NDMS Federal Coordinating Center representative is in your region. Plug in, and advise on all matters related to Aeromedical Evacuation, if applicable.
- Review your base's MCRP: Consider resources available in your civilian community, and determine if they may be useful during a crisis. If so, draft an MOU and make it official.
- As always, be sure to stay in your lane. Base disaster response plans should have mil-civil support boundaries and be sure not to go astray from them (see Joint Publication 4-02 for more). When in doubt, check with your JAG.

Networking with your fellow emergency preparedness professionals and becoming your community's

military disaster response expert can pay significant dividends. For better or worse, recent events have demonstrated that the public often turns to the military when disaster strikes and we must be ready to deliver. Also, remember that we in the military are often the targets! Foiled attacks against Ramstein AB and Fort Dix have demonstrated that we must be ready for the next major disaster. So put down the coffee, pick up the phone, call over to your counterpart at the fire department, offer to buy lunch, and start networking! I encourage each of you to take some time and rub elbows with your fellow emergency planners before disaster strikes.

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Deployment Feedback from the Field

Capt David Johnson, CASF - Ali Al Salem, Kuwait

My deployment to Ali Al Salem, Kuwait during the 7/8 cycle was a new and exciting avenue in my military career. I was part of the 386 Expeditionary Medical Group and functioned as the Officer in Charge of the Medical Control Center. My main function was overseeing Inter and Intra-theater movement of 1,100 patients where we maintained a 100% mission on-time rate during 7 X 24 hour operations. In addition, my team managed Intra-theater emergency transport for both GI's and civilians to higher-level locations of medical care. The 386 EMDG/CASF was also the center of base medical communication with the wing and external allies.

Once the previous deployers departed in late-May, "the newbies" didn't conduct a mission for almost two weeks. We used this experience as a springboard for higher levels of success. The aircraft used included C-17's, C-130's and helicopters. The workload became busier as time went on and previous quiet days no longer remained quiet. As more and more patients came through my team than before, I began to look at these wounded warriors as true heroes versus mere statistics.

We integrated a Battle Injury recognition program to honor those injured in actual battle or IED blasts. A sobering moment came when an injured GI, of whose current status I had tracked per my commander, passed away due to injuries he obtained during an IED blast. After reading about this individual's background in the news, I was moved at how this became so much more than simply tracking a name for the commander. Vigils were held for this individual on base as well at another military installation.

My additional responsibilities included metric tracking of the MEDRED-C. This provided CENTAF with visibility of the current patient movement statistics, manning and operational status for our facility. I also had oversight of PERSCO notifications and Patient Administrative functions. Our AEF revamped both of these programs to ensure accurate personnel tracking procedures were maintained.

I also had the opportunity not only talk with many of the patients that passed through but also meet other people on the base (both U.S. and Korean Forces). Each Tuesday, I and several others would walk to the Korean compound and teach English. Sharing and comparing the western and eastern cultures over indigenous food and scintillating conversation is an experience that I cannot put into words. The Koreans are very appreciative of the US Forces and very gracious. Meeting new people and experiencing a new work dynamic helped focus me toward what is truly important...without the people, there is no mission.

Capt Wendy Mack CASF-Balad, Iraq

One of the top ten experiences in my MSC career was deploying to Balad, Iraq to be part of the CASF. At Balad, I was part of the Tuskegee legend as the 332 EAMDS/CASF and what a time it was. I was the Director Operation during the night shift. My main function was in Command and Control overseeing the

manifesting of patients, ensuring their baggage was taken care of and that the overall operations went smoothly. Of course as any good MSC, I had several metrics to keep track of to include doing the SITREP and MEDRED-C each night at midnight. Since we were the last stop before leaving the AOR, we also had the responsibility to be Custom Border Certified Agents (CBCA) and ensure that the patients/attendants bags were cleared.

Night shift equated out to the “busy time” as I found out most of the missions occurred at night. During the week, our missions were between 20-60 patients with approximately 50% of that being litter patients. There was a Germany mission almost every night and on average 2-3 Intra-Theater missions a week. Since we were the last stop before Germany, we had many CCATT patients (on average 1-2 a night) flowing through our system. During the four months of deployment, we had 4,000+ patients come through Balad; it made for a busy tempo.

I saw many devastating injuries, but even more heroes come through our doors who all wanted to do their part. I tried as much as I could to talk with patients and hear their stories. What amazing soldiers, seaman, marines and airman; it really reminded me why I was there and put things into perspective.

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MSCs Shoot Too!

Capt William Hinson Jr.

Office of the Command Surgeon Camp Eggers, Afghanistan

I am an active duty Air Force MSC currently serving in Afghanistan. My current position at Camp Eggers, Afghanistan encompasses managing financial operations for the command surgeon's office. I have also spent time in Kuwait, Iraq, and Haiti when assigned to the 43rd Aeromedical Evacuation Squadron (AES) at Pope AFB. I love the versatility of being an MSC, absolutely loved tactical aeromedical evacuation at the 43 AES. I could be wrong, but I'm pretty sure I was the first Air Force MSC to fire a shot in Iraq when the marine convoy we were in got caught in an ambush. On this convoy, I was under the leadership of another Air Force MSC, Lt Col Jim Sterling. He was riding two vehicles behind mine. The 19 Air Force members in our group were awarded Air Force Commendation Medals with Valor for our time in Iraq.

Once, I deployed to Haiti with a “no warning” seven-hour notice phone call at 0130 on a Sunday. I reported in uniform with bags by 0800, not knowing where I was being sent at first. I was only told to wear “greens” instead of desert camo. We were on a bird for Haiti by 1030. We arrived in Haiti around 1700 and we were moving our first patient, an American reporter with a gunshot wound to the neck, within an hour of boots-on-ground.

I have worked with coalition forces from many different countries on each of my deployments. I have experienced some of the worst dust storms in recent recorded history in Iraq; terrible wind storms in Kuwait; 28 days of not being able to take a shower in Iraq; no “facilities” to speak of for a few weeks (use your imagination on the “facilities” reference) -- fun times! I about had a heart attack when we had to ration our food and water for a short period. During one 2-3week convoy I lived 24/7 in Mission Oriented Protective Posture (MOPP) 2 (this means over garments and overboots worn with gloves and mask readily accessible) to include battle rattle & weapon. I convoyed into Iraq with the 1st Marine Expeditionary Force (MEF) in '03 just 12 hours behind the initial ground assault; our Air Evacuation teams were the first in history to go that far forward in a combat environment. The 1MEF received their unit's 9th Presidential Unit Citation for this part of the invasion, and it was also noted that this was the deepest penetrating ground operation in Marine Corps history.

The training & experience I have received through the years has helped me tremendously in both enlisted and officer roles, however I would put more emphasis on the experience I gained at the 43 AES than at any other location I've ever been assigned to. I encourage all MSCs to consider serving at least one aeromedical evacuation tour. Aeromedical evacuation offers opportunities and challenges that you just will not find at a medical treatment facility. No matter how much you train though, I have seen that "EXPERIENCE" is still the best teacher. No amount of on-line training, or classroom didactics, or field exercises can fully prepare you for the real deal. One "key" to successful deployments is flexibility. If given the opportunity to spend some more time in AE during my career, I wouldn't hesitate to accept the challenge.

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Wing Exec for a Year

Capt Bryan Jernigan

"It was the best of times, it was the worst of times..." as the great Charles Dickens proclaimed in A Tale of Two Cities, referring to the French Revolution. Today I use the phrase to describe my 15 months of tenure as the Executive Officer to the 95th Air Base Wing Commander.

"We're looking for a few good CGOs to interview for a great opportunity." Sounds like the normal recruiting slogan for any detail or job, but this was much more. After interviewing with Colonel H. Brent Baker, Sr., the incoming Wing Commander, I was competitively selected to be the Executive Officer at the 95th Air Base Wing. I thought I was adequately prepared for the job...I was wrong.

I was prepared for managing the suspenses due to the Wing, Center, and Higher Headquarters. I purchased a book 3 weeks prior to my start date entitled "Total Workday Control, Using Microsoft Outlook" by Michael Linenberger. It laid out techniques for managing large volumes of email and tracking tasks thru to completion. It took me a few weeks to learn and discipline myself to use the system, but it proved to be my savior. This single system enabled me to process 150+ emails per day, many with suspenses or tasks, and have 100% on-time rate. Without it, I would have failed miserably.

I was prepared for email correspondence...I thought. We all write emails everyday, but how many of those emails concisely express what needs to be said to avoid numerous follow-up emails seeking clarification. First and foremost, write a significant subject line and if there's a due date...put it in the subject. Secondly, write a Bottom Line Up Front (BLUF), which is a brief executive summary so recipients can immediately identify if they need to read further and respond. This is followed with a details section, in which I fully explain and support the message with facts and attachments. Lastly, review the message to ensure 1) conveys precisely the message intended; 2) is professional, and 3) would be OK if made public.

I was not fully prepared for a zero-error expectation of performance. I'm human and I do make mistakes, but as the exec an error can send the wrong message to 1,000's of people, cost someone a promotion, or worse. This is where a keen eye for attention to detail and having a penchant for perfection definitely helped. Warning, if you are error prone or sensitive to having mistakes pointed out...this job is definitely not for you.

I was not prepared for carrying a Blackberry everywhere and the loss of the liberty to take leave freely. There were some very long hours and many weekends I went in to work to catch up on emails, OPRs, PRFs, EPRs, LOAs, decorations, mail, etc. With that said, you must engage your family before taking on a job of this magnitude. I was fortunate that my wife understood the commitment and supported me.

The biggest surprise though, was that I had a lot of fun. I worked with an exceptional support staff that is undoubtedly the cream of the crop here at Edwards. Colonel Baker frequently referred to his staff as his extended family and not only did we spend many office hours together, we all spent several holidays with him and his family. The takeaway is that if people enjoy their work environment, their productivity will exceed anything spelled out in a feedback session.

I was least prepared for the 9th of August, 2007, my last day as exec. I was sad to leave because while it was a very demanding job, it was also the most rewarding job I've ever had. I witnessed first hand the inner workings of an installation commander's office; why decisions were made and how they would affect the base in the future, as well as what political or legal ramifications could result from an action or endorsement. I had the distinct honor of working for Colonel Baker and Colonel Gallagher (the new Wing Commander) and after witnessing first hand their actions/motives/leadership...I understand exactly what Service is. I cannot quantify any tangible rewards from being an exec (I'm still at Edwards after all), but I can say I understand there's a bigger picture of the Air Force that most CGOs will never experience. In addition, I received mentoring from a line officer with 29 years of service that has made a lasting improvement in my efficacy, leadership abilities, communication skills, and personal life.

So if you're offered a chance to compete for an Executive Officer position, first and foremost know what you and your family are getting into. Without the constant support of my wife, Patricia, the job would have eaten me alive. If you're still interested, then sign up, strap in, and hang on for the ride of your life.



HSA Welcomes Instructor

Major Dee Ann Mejia
Course Director, HSA

The Health Services Administration (HSA) Course welcomed Capt Douglas Stevens as its newest instructor on 31 July 2006. Capt Stevens is the first "Fellowship" trained Health Plan Management instructor in school history. He was selected for this unique AFIT-sponsored fellowship opportunity because of his extensive experience within the Health Plan Management specialty. He attended the 10-month Fellowship at Wilford Hall Medical Center, TRICARE Operations and Patient Administration Division, 59th Medical Wing, Lackland Air Force Base, Texas for the sole purpose of becoming an HSA instructor.

Capt Stevens has over 22 years of diverse healthcare experience ranging from clinical laboratory science to hospital administration. He has 3 years prior experience as an instructor for the Phase II Medical Laboratory Technology Course at Eglin Air Force Base, Florida. Capt Stevens is a 2003 graduate of the U.S. Army-Baylor Program in Healthcare Administration (MHA). No stranger to academic presentation, his thesis/graduate project, *Competencies for the 21st Century Healthcare Administrator*, was selected and presented at the 2004 American College of Healthcare Executives (ACHE) Conference. Most recently, Capt Stevens was a featured "Break-Out" speaker at the Military Health System (MHS) Leadership Conference in 2007. His presentation, *Driving Change Through Health Plan Management*, described business plan and access to care improvements implemented at Wilford Hall Medical Center.

We welcome Capt Stevens, his wife, Kayla and their four children to the HSA family!

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IMPROVING PATIENT ACCESS THROUGH A BALANCED CAPACITY MANAGEMENT OPTIMIZATION PROGRAM

2008 MHS Conference Health Innovations Program Submission

Maj Robert Harris, Senior GPM 60 MDG

Introduction:

The USAF David Grant Medical Center (DGMC) leadership established a 2007 Strategic Objective to “Optimize healthcare operations through a centralized capacity management function, balancing appointment supply and demand across the spectrum of healthcare.” Senior leadership set this goal in response to patient complaints regarding access to care, as well as sub-optimal Air Force Medical Service (AFMS) Business Plan performance. A system-wide approach was used initially focusing on the Primary Care Product Line (PCPL). The desired outcome was to create a healthcare delivery system matching the right patient to the right provider at the right time to improve patient service and resource utilization. A multifaceted, comprehensive process improvement action plan was developed targeting several critical programs. These programs included; balancing the consumption of healthcare resources across clinics and providers, forecasting patient demand and establishing daily clinic appointment targets, establishing a centralized scheduling and template function, implementing standards and accountability, and providing leadership with decision making information.

Internal analysis regarding appointment availability was accomplished based on AFMS web-based tools, and locally developed information management tools using CHCS ad-hoc reports. In addition, the USAF Surgeon General’s Service Delivery Assessment (SDA) report was used to measure patient satisfaction with access to care. The following milestones were achieved; the average patient encounters/month 27% in the PCPL; FY07 Business Plan execution was 117% in the PCPL and 118% overall for DGMC; in 12 months customer satisfaction for access to care related metrics climbed to their highest levels ever. The SDA ‘Ease to Make Appointment’ metric gained 11% to 94%; and the SDA ‘First Call Resolution’ metric rose 15% to 89%. In addition, the increased appointment capacity has reduced access related CHCS t-cons to nurses, allowing a better utilization of nursing resources.

Methods:

Of paramount importance in the capacity management optimization program was the support of senior leadership. The Medical Group Commander and his executive team established a clearly defined vision and mission statement for this program. In 2007 the number one DGMC Strategic Objective was to optimize healthcare operations through a centralized capacity management function, balancing appointment supply and demand across the spectrum of healthcare. Specific goals and milestones were identified in support of this objective. These objectives allowed the Group Practice Management (GPM) function to establish an action plan linking objectives to clearly quantifiable measures. Management tools were built to make work visible, as well as to measure progress at a very granular level of detail. The status of the program was frequently reported to senior leadership. In addition, efforts were placed on improving communications and feedback between leadership and the outpatient clinics. This led to improved two-way communications effectively increasing clinic accountability and ownership for patient access to care. In addition, frequent reporting provided senior leadership with visibility of clinical resourcing constraints and disconnects. The capacity management optimization initiative realized the following objectives:

1. Establishing Standards and Accountability: When the objective was conceptualized, there was not a productive management forum in which to discuss healthcare operations. From the ashes of a defunct TRICARE Steering Group (in which death by PowerPoint was the norm) arose a Healthcare Operations Steering Group (HOSG) which tackles access issues head-on. The HOSG was designed and chartered as a pro-active, action-oriented, and highly flexible steering group. The HOSG has two primary focuses; 1)

identifying and ameliorating future healthcare delivery constraints, and 2) explaining negative variances in healthcare operations. Underperforming clinics are asked to explain their deficiencies (access to care, business plan production, capacity related specialty referrals to the network, etc.), as well as to establish action plans for improving operations. Essentially, the HOSG became the Medical Group Commander's spot light for maximizing resource utilization and improving patient access to care.

In addition to creating a forum to discuss access and healthcare operations, the appointment and schedule management policy received a major overhaul. The new policy defined accountability, responsibility, and ownership. It also codified processes to ensure both TRICARE access standards and AFMS business plan targets were achieved. Highlights of the policy included; setting a 35 day standard for all outpatient clinic schedules to be open, establishing minimum clinic staffing levels, standardizing provider administration time, identifying the authority for cancelling provider schedules, setting a standard for establishing clinic appointment targets, and mandating the utilization of the Access Heads-up Display (HUD) to monitor access including both the number of days a clinic schedule is out, as well as daily clinic access.

2. Establishing a Centralized Scheduling and Template Management Function: Prior to this initiative all template and schedule management was decentralized to the clinics. There was a lack of visibility and oversight regarding provider and clinic schedules. In addition, there were dozens of technicians with the ability to create/modify/delete provider schedules. This non-standardized system created a complete lack of oversight and accountability. To shore up these access vulnerabilities, a Centralized Scheduling and Template Management Function was created. Two medical administration technicians were matrixed to support this new responsibility. This function managed by the GPMs assumed direct oversight and management for 97 provider schedules in the Primary Care Product Line (PCPL). Additionally, a strategy of centralized oversight, and decentralized template & scheduling execution was implemented for the remaining 50 outpatient clinics. Since its inception, the capacity management function has benefited from economies of scale (2 FTEs now accomplish what it took 9 FTEs to previously complete). Processes have been implemented to improve scheduling oversight and to reduce variation including improved schedule and template discipline. In addition, improved leadership visibility pertaining to patient access to care has increased accountability.

3. Knowledge is Power: Providing Leadership with Decision Making Information: One of the goals related to optimizing healthcare delivery was to provide leadership with decision making information.

Two information platforms were developed; a strategic Business of Medicine (BOM) report, and a tactical access Heads-Up Display (HUD).

The BOM is a management tool designed as an executive summary of Medical Group healthcare operations comprised of key metrics. The BOM pushes information in two directions; a concise two-page Word document, and an in-depth PowerPoint file. The BOM is used as the metric backbone to spur review and discussion at the Healthcare Operations Steering Group (HOSG).

The HUD was established to provide pin-point accurate and near real-time visibility of access to care. The HUD is an automated tactical capacity management tool. The HUD enables leadership to measure access on a granular level against an established daily appointment target. The HUD also allows leadership to keep their eyes on the access horizon by providing visibility of the number of days a clinic schedule is out. Capabilities of the HUD include: measuring clinic appointment access against a daily appointment target (drill down capability to the clinic, element, provider level); appointment type and quantity; identifying the delta between appointment supply and forecasted patient demand; provider availability; identifying the number of appointments available for booking; and, showing the number of days into the future the clinic schedule is open for booking. HUD 1.0 focused on the PCPL. HUD 2.0

which is currently under development will include specialty clinics. The HUD operates on a MS Access platform and is populated by CHCS data via an ad-hoc report.

4. **Balancing the Consumption of Healthcare Resources:** In order to ensure that patients' needs are met, and that medical resources are best utilized, DGMCC created an automated Focused Empanelment tool. The Focused Empanelment database tool matches a patient's acuity with a provider's skill. Patient acuity is based on a patient's consumption of medical resources over a 24 month period. To determine acuity, the following factors are used: PCM, specialty clinic, and ER encounters; RVUs generated; admissions; and RWPs. This information is analyzed and patients are placed in the appropriate primary care clinic with an appropriate PCM based on their healthcare needs. Additionally, a Patient Vectoring tool which estimates a patient's future consumption of resources is used for new DGMCC TRICARE enrollees. Both of these systems stratify patients by acuity for placement with appropriate providers. An added benefit of these tools is the ability to quickly and appropriately reempanel patients enrolled to Family Medicine Graduate Medical Program residents. In 2005, building appropriate resident patient panels was accomplished in five months. In 2007, this process was completed in three days. This approach to patient-PCM assignment ensures the right patient is enrolled to the right provider, and that finite healthcare resources are best utilized.

5. **Hitting the Target (building a system to meet patient demand):** Daily appointment targets were established for each primary care and specialty clinic. Primary care targets were determined by estimating annual patient workload based on historical patient utilization rates, patient population, the number of days the clinics are open for patient care. This value was multiplied by a buffer to estimate the number of clinic appointments that would have to be created in order to create adequate patient access to meet the forecasted workload. The buffer consists of the following values; estimated unmet demand, and non-utilized (unbooked/facility cancelled, and no show) appointments. Once the daily appointment targets are established, they are vetted to senior leadership for approval. Approved targets are loaded into the HUD and tracked for compliance. To quickly identify access pinch-points the HUD uses a stop-light methodology (red < 90%; 90% >= yellow > 100%; green >=100% of target). Clinic leaders are required to explain red/yellow access to care values at weekly executive staff meetings, as well as at the monthly HOSG.

Results:

Since this program was initiated in January, the results have been astounding. The efficacy of this initiative is evident in both customer service and business performance. As measured by the Air Force Surgeon General's Service Delivery Assessment, customer service metrics have been strongly trending upward. Between Aug 06 and Aug 07, the Ease to Make an Appointment metric increased by 11% to 94%, and the First Call Resolution metric gained 13% to 87% (hitting a high of 89%). These values are the highest ever achieved at DGMCC. Overall Patient Satisfaction increased from 94% to 96%. One example of improved access is evident in the Family Medicine GME resident transition schedule. During the summer of 2006, access to care was less than 7 days. In the summer of 2007, the appointment schedule was open for booking 35 days out. These improvements in customer service are also supported by significant growth in outpatient productivity.

In the first 7 months of CY07, the average patient encounters/month in the PCPL increased 2,704 (27%) as compared to CY06. The average monthly RVUs also increased by 2,830 (34%) for the same period. Gains were more significant in the primary care, family medicine, and internal medicine clinics which were directly managed by the Centralized Scheduling and Template Management Function. These clinics improved their encounters/month by 2,783 (39%) and RVUs/month by 2,583 (42%). These improvements are validated by the FY07 Business Plan (Oct 06 – Jul 07) performance. The cumulative RVU execution is 102,151 (117%) in the PCPL and 292,777 (118%) overall for DGMCC. The data source is the AFMS BP Radar, RVU-encounter report.

The goals achieved in this program have also resulted in other intangible benefits. The increased appointment capacity has reduced access related nurse T-Cons, thus improving nurse utilization. In addition, consolidation of PCPL templates and schedules management into one function enabled seven medical administrative technicians to better support clinic provider staff.

Conclusion:

In 2007, DGMC achieved unprecedented results in improving patient satisfaction with access to care by executing a dynamic capacity management program. The commitments from both senior leadership and clinic staff to ensure patients receive the healthcare they require is ensuring this program's sustainability. The HUD is reviewed by clinic staff on a daily basis and by senior leadership at least once a week. In addition, the HOSG is dynamic forum for communicating access issues across the continuum of healthcare operations. The drive towards improving patient access to care has become institutionalized across the organization.

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ACHE Awards Call for Nominations

Col Perry Cooper, AF ACHE Regent

Each year, ACHE Regents solicit nomination for two prestigious awards: *Early-Career Healthcare Excellence Award* and the *Senior Level Healthcare Executive Award*. These awards are renowned throughout the MHS and private sector, and for the first time Enlisted Affiliates are now eligible to compete. Winners are recognized in ACHE publications and presented their awards during the AF Dinner at the ACHE Congress on Healthcare Leadership.

To be eligible for these awards, the recipients must be active ACHE affiliates or individuals who have contributed to healthcare management but are not eligible for membership. The following criteria will be evaluated by the Awards Committee in the selection process:

Early-Career Healthcare Executive Award:

- ◆ Serving in the Rank of Major or TSgt and below
- ◆ Nomination Package Headings:
 - Certifying statement that the nominee is an affiliate of the ACHE
 - Demonstrated leadership ability
 - Demonstrated innovative and creative management
 - Executive capability in developing his/her organization and promoting its growth and stature in the community
 - Participation in local/state/provincial hospital and/or Air Force Medical Service health related activities
 - Participation in civil/community activities and projects
 - Demonstration of participation in ACHE activities and interest in assisting ACHE in achieving its objectives

Senior Level Healthcare Executive Award:

- ◆ A Senior level executive (Lt Col or MSgt and above)
- ◆ Nomination Package Headings:
 - Certifying statement that the nominee is an affiliate of the ACHE
 - Demonstrated leadership ability
 - Demonstrated innovative and creative management
 - Executive capability in developing his/her organization and promoting its growth and

- stature in the community
- Participation in local/state/provincial hospital and/or Air Force Medical Service health related activities
- Participation in civil/community activities and projects
- Demonstration of participation in ACHE activities, contributions to ACHE objectives and commitment to ACHE Code of Ethics

Using the headings noted above, nominations should be submitted on an AF Form 1206 and limited to two pages (front and back of one form). Nomination packages should include 1206, copy of nominees' biography, and a cover letter signed by the nominees' supervisor or commander. These packages should be forwarded to Maj Patrick Misnick with Cc to MAJCOM/SGA (electronic copies are preferred).

The following schedule will be followed:

- 15 Nov 07 - Call for Nominations and 1206 templates sent to MAJCOM SGAs
- 15 Jan 08 - AF Nomination Packages due to Maj Misnick
- 16-31 Jan 08 - Awards Committee scores packages
- 4 Feb 08 - Awards Committee sends recommendations to Regent (Col Perry Cooper)
- 8 Feb 08 - Award selections due to ACHE

Questions regarding the above awards may be addressed to Maj Patrick Misnick at (301) 619-8563 (patrick.misnick@detrick.af.mil).

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AFPC Update:

Are you hot for a 365-Day Extended Deployment?

Capt Melissa Curreri, AFPC/DPAMS

In early 2005, the Air Force Chief of Staff directed certain key positions in the AOR to be filled by Airmen serving on 1-year extended deployments. Current requirements include almost every major career field. The program has expanded from 200 requirements in 2005 to well over 1,200 for 2008.

To date, for Lt Col's and below, the MSCs have 25 extended deployment requirements. What the future holds is unknown at this time. We currently have 4 Captain, 19 Major and 2 Lieutenant Colonel requirements. We did solicit volunteers for all positions. We received 18 volunteers: 13 active duty, 4 reservists and 1 Air National Guard.

Since there were more requirements than volunteers for our 2008 extended deployments, AFPC had to resort to the selection of non-volunteers to fill the remainder of these requirements. Per the 365-Day Extended Deployment guidance the criteria used for non-volunteer selection is threefold. The first consideration is the number of short tours conducted. Those members with the most short tours move to the bottom of the non-volunteer list, regardless of when those short tours were conducted and those with no short tours move to the top of the list. The second consideration is Short Tour Return Date (STRD). This date can be the date you came on active duty (if you've never served on a short tour), the date you returned to the CONUS from a short tour location, or a date that was adjusted based on other previous deployments you served on (as long as it was to an overseas location for 2 or more consecutive days). The third consideration is Overseas Duty Selection Date (ODSD) which only comes into play when two or more members have the same number of short tours and the same STRD.

A common misunderstanding has been that a current normal AEF cycle or 179-day deployment keeps you from being selected as a non-volunteer for an “extended” deployment. According to the 365-Day extended deployment guidance, members receive a 6-month deferment upon returning from a deployment before they can attend training as a non-volunteer for an “extended” deployment. As noted previously, your STRD is adjusted by the number of days you were deployed.

Another misunderstanding is that an overseas long tour keeps a member from being selected as a non-volunteer for an extended deployment. A long tour adjusts a member’s Overseas Duty Selection Date (ODSD) and not their STRD.

How can you find out your STRD and ODSD? Your SURF contains your STRD and ODSD. Check your dates and keep them current at all times. If you find a mistake your CSS or MPF can help you get those dates adjusted.

Please contact us if you have questions regarding your STRD or where you are on the non-volunteer list. We want to make sure you have all the information you need to stay informed.

COO Duty Title Change

Lt Col Brian “Hoosier” Riggs, AFPC/DPAMS Chief

The MSC DT has reversed an earlier decision to allow Administrators to use the Chief Operating Officer (COO) duty title. Accordingly,

- 1) Those individuals currently assigned as Administrators that have an OPR reflecting the COO duty title may retain the COO duty title until they depart their current assignment.
- 2) Those individuals currently assigned as Administrators that do not have an OPR reflecting the COO duty title must amend their duty title to Administrator.

Please work with your CSS to ensure your SURF reflects the appropriate duty title.

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CONGRATULATIONS/ANNOUNCEMENTS CORNER!

CY07 Air Force Medical Service Developmental Education (DE) Program Selections:

GR	NAME	PROGRAM
LTC	MOUNTS STEPHEN M	NWC
LTC	LANDON HEATHER M	AWC
LTC	PFAFFENBICHLER DAVID W	AWC
LTC	REESE STEVEN B	AWC
MAJ	GUILLORY MARGUERITE M	ACSC
MAJ	HOOPER JEREMY N	ACSC
MAJ	LAGROU EDWARD J	ACSC
CPT	ANDERSON DELORES A	FORCE MGMT/STAFF BOLLING FEL
1LT	BASHAM AMY M	ARMY BAYLOR MHA
CPT	BEATY JOYCE C	LEHIGH VALLEY EWI
CPT	BYRD LAUREN	USAFE EXPEDMED OPS (EMOPS) FEL
MAJ	CHISOLM JAMES	HLTH SOUTH EWI
CPT	CLEVELAND MARK E	RESOURCE MGMT FEL (SAF/FMB)
CPT	COLEMAN GREGORY A	USAF PROGRAM (A8PL) FEL
1LT	DEAN JOSHUA D	ARMY BAYLOR MHA/MBA
MAJ	ESTRIDGE CHRISTOPHER J	MED LOGISTICS AFIT MAS
CPT	FARMER THOMAS S	HQ AETC READINESS FEL
1LT	GILSON GLEN N	ARMY BAYLOR MHA/MBA
CPT	GONZALES SAMUEL R	ACC MED READINESS FEL
CPT	HUINKER DAVID	INFO MGMT MAS CIVILIAN
CPT	JENKINS KIRK T	VA HLTH ADM FEL
MAJ	KELLER RICHARD A	MED LOGISTICS EWI LMI
CPT	KELLETT NATHAN T	OHIO STATE UNIV IM/IT EWI
CPT	MAREK CHARLES E JR	AEROMED EVAC PLAN FEL TACC
MAJ	MONTGOMERY ALEXANDER G	MED READINESS FEL 79 MDW
CPT	MULLEN JAMES F	ACC HOMELAND DEF FEL
MAJ	PERRY KENNETH C	AETC TOPA FEL
1LT	PETERSON RORY A	CIVILIAN MHA
CPT	SCOTT VIRGIL L	JOHNS HOPKINS EWI
MAJ	SPOON-LECOUFFE BETH A	AFMC/SG EXPED OPS FEL
MAJ	THOMPSON ANGELA M	PACAF MED READINESS FEL
CPT	TIPPINS TRACIE R	AFSOC-READINESS FEL
1LT	VANCE KELSEY J	CIVILIAN MHA
MAJ	VASSAR MARIA D	AETC RESOURCE FEL
CPT	VOLLENWEIDER KEITH M	USSOCOM MED PLAN FEL
MAJ	WEBB RANDALL	IM/IT INFO MGMT ASSURANCE FEL
CPT	WESTON EBONY	MAYO CLINIC EWI
1LT	WETHINGTON TOBIE A	IM/IT MAS CIV
CPT	WILLIAMS SHAUNDRA D	BEN TAUB EWI

The Following MSC Officers are Alternates for the DE Programs Below:

GR	NAME	PROGRAM
CPT	WHALEN, JOCELYN M.	AFIT #1
CPT	HERNANDEZ LIANA L	AFIT #2
1LT	ALLEN BRIAN R	AFIT #3
CPT	FEWELL JEFFERY	AFIT #4
1LT	MILLER RAYMOND A	AFIT #5
CPT	MERRITT NORA	HLTH PLAN MGMT #1
CPT	CARUTHERS BRIAN	HLTH PLAN MGMT #2
MAJ	ADAMS ARLENE D	HEATLH PLAN MGMT #3
CPT	BUSSIE LYNNE M	INFO MGMT/INFO TECH #1
MAJ	GILBERT-STEEL RASHONE	INFO MGMT/INFO TECH #2
MAJ	GILBERT-STEEL RASHONE	READINESS #1
CPT	KERSTEN MICHAEL J	READINESS #2
CPT	MERRITT NORA	READINESS #3
CPT	TATUM DAVID	READINESS #4
CPT	TOWNSEND-ATKINS PAMELA	READINESS #5
CPT	CARR LISA D.	READINESS #6
CPT	BUSSIE LYNNE M	RESOURCE MGMT #1
CPT	REYNOLDS MARK D	RESOURCE MGMT #2

Recent or upcoming MSC Retirements: Farewell and Best Wishes for a Successful Future!

Col Randy Borg
Col Patricia Gaulty
Col Marc Sager
Col Charles Wolak
Lt Col Lou Ferrucci
Lt Col James Fish

Lt Col Roger Spondike
Lt Col Gregory Stewart
Major Chris Grippo
Major Richard Hawk
Major Kathleen Spitzer

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ANNOUNCEMENTS

Colonel Robert Hamilton is the new Associate Corps Chief for Administrators, replacing Colonel Randy Borg who retired 5 Oct 07. Colonel (sel) Leslie Dixon replaced Col Hamilton as the AMC/SGA MSC Senior Council Member. Colonel Kevin Glasz replaced Colonel Wardell as the Associate Corps Chief (ACC) for Financial Management. Colonel Wardell is the new Chief of Staff, Joint Task Force National Capital Region Medical (JTF CapMed).

Check out the updated MSC KX webpage at <https://kx.afms.mil/msc>. If have not already subscribed to the MSC KX site, please do so now. This is the best way to keep posted on what is happening with the Corps. If you have suggestions for the MSC site, please contact [Maj Tyler Sanders](#).

Important 2007 Board Dates:

- 27 Nov-14 Dec - Lt Col/Col Promotion Board

Upcoming Events:

- HSA Graduation, 6 Dec 07
- 28-31 Jan 08, MHS Conference
- 12-14 Feb 08, Developmental Team (DT)/MSC Senior Council Meeting
- [HIMSS Annual Conference & Exhibition](#), 24-28 Feb 08, Orlando, FL
- [ACHE Congress on Healthcare Leadership](#), 10-13 Mar 08, Hyatt Regency, Chicago, IL
- Intermediate Executive Skills (IES)/SGA Course, 21 Apr – 2 May 08, Sheppard AFB, TX

Recommended Reading:

- [Airmen \(USAF MSCs\) mentorship helps develop Afghan hospital](#)
- [“Secretary Gates Declares War on the Army Brass”](#)
- [“A Failure of generalship”](#)
- [“Uniform Services Add Depth to Field”](#), Dr. Thomas Dolan, President & CEO ACHE
 - ACHE Affiliates can also view this article at www.ache.org

From the Editor

Maj Tyler W. Sanders

MSC Force Structure Management Fellow

I was expecting Air Staff to be busy, but I have to admit that was probably the quickest summer of my Air Force career. Since the last article, I've had the pleasure to attend 2 DTs, the IES/SGA course, MSC Association reunion, AFMS Conference at Leesburg, hosted the YHCA group in D.C. and attend AAMA. I've had an incredible experience in my Fellowship and the chance to meet many of the folks in our Corps. I often get asked about updates and what is happening in our Corps. I try to post everything possible to the MSC website on the KX (<https://kx.afms.mil/msc>). I highly encourage you to subscribe to our website so you can be notified of changes. Also, to keep the information flowing to you all, we will go back to publishing 4 newsletters per year in 2008.

Please do not hesitate to call or email with questions or comments. Also, if you'd like to submit a newsletter article or announcement, please email to me at tyler.sanders@pentagon.af.mil. I look forward to hearing from you.

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